

MISSOURI DIVISION OF HEALTH - STANDARD CERTIFICATE OF DEATH

DEPARTMENT OF PUBLIC HEALTH AND WELFARE

-62-000308

AMENDED

Registration District No.

042

Primary Registration District No.

1000

Registrar's No.

42

STATE FILE NUMBER

FILED JAN 22 1962

1. PLACE OF DEATH a. COUNTY Buchanan		2. USUAL RESIDENCE (Where deceased lived. - If institution? Residence before admission) a. STATE Mo b. COUNTY Buchanan	
b. CITY (If outside corporate limits, give TOWNSHIP only) OR TOWN St. Joseph		c. CITY OR TOWN St. Joseph	
Length of stay in 1b 60 yrs		Inside Limits Yes <input checked="" type="checkbox"/> No <input type="checkbox"/>	
c. FULL NAME OF (If NOT in hospital, give location) HOSPITAL OR INSTITUTION O.O.A. St. Joseph Hosp		d. STREET ADDRESS (If outside, give location) 609 1/2 No 10th	
Reside on Farm Yes <input type="checkbox"/> No <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print) First Middle Last Francis L Bonar		4. DATE OF DEATH Month Day Year Jan. 6, 1962	
5. SEX Male	6. COLOR OR RACE White	7. Married <input checked="" type="checkbox"/> Never Married <input type="checkbox"/> Widowed <input type="checkbox"/> Divorced <input type="checkbox"/>	8. DATE OF BIRTH Sept. 26, 1891
9. AGE (last birthday) 70		10. IF UNDER 1 YEAR Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Re. Laborer		10b. KIND OF BUSINESS OR INDUSTRY Sewer Contractor	
11. BIRTHPLACE (City and state or country) Stonington Colo		12. CITIZEN OF WHAT COUNTRY U.S.A.	
13a. FATHER'S NAME Henry Bonar		13b. MOTHER'S MAIDEN NAME Unk	
14. NAME OF HUSBAND OR WIFE Mary Bonar		15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) yes WWI	
16. SOCIAL SECURITY NO. [REDACTED]		17. INFORMANT Mary Bonar	
18. CAUSE OF DEATH (Enter only one cause per line) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Unattended Death-Apparently Natural Causes- Conditions, if any, which gave rise to above cause (a), stating the underlying cause last. DUE TO (b) Investigated by the City Health Department. DUE TO (c)		INTERVAL BETWEEN ONSET AND DEATH	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH but not related to the terminal disease condition given in PART I (a)		PART III. If deceased was female was there a pregnancy in last 90 days. <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No <input type="checkbox"/> Unknown	
19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	20a. ACCIDENT <input type="checkbox"/> SUICIDE <input type="checkbox"/> HOMICIDE <input type="checkbox"/>	20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in PART I or PART II of item 18.)	
20c. TIME OF INJURY Hour a.m. p.m. Month, Day, Year	20d. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>		
20e. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		20f. CITY, TOWN, OR LOCATION COUNTY STATE	
21. I attended the deceased from _____ to _____ and last saw her alive on _____. Death occurred at 8:30 A.M. on the date stated above, and to the best of my knowledge, from the causes stated.			
22a. SIGNATURE Robert M. Kiebert, M.D.		22b. ADDRESS St. Joseph, Mo	
22c. DATE SIGNED 1-16-62			
23a. BURIAL, CREMATION, REMOVAL (Specify)	23b. DATE 1/19/62	23c. NAME OF CEMETERY OR CREMATORY Odd Fellows Public Cemetery	
23d. LOCATION (City, town, or county) St. Joseph, Mo			
24. FUNERAL DIRECTOR John E. Kiebert		25. DATE RECD. BY LOCAL REG. Jan. 19, 1962	
26. REGISTRAR'S SIGNATURE Wm. Clark Handell			

DOCUMENT

MEDICAL CERTIFICATION

BY AFFIDAVIT OF

R.W. Kiebert, M.D.

AMENDMENTS ON THIS RECORD ARE AS FOLLOWS

DATE AMENDED

INSTEAD OF

SHOULD READ

ITEM NO.

JAN 22 1962

STATEMENT BY LICENSED EMBALMER

I hereby certify that the body whose name is recorded on the reverse side of this certificate was embalmed by me,

body, Student Embalmer No. _____

working under my personal supervision.

Student _____

Signature of Student Embalmer

Signed _____

Licensed Embalmer No. 3986

P. O. Address St. Joseph, Mo.

Note: The above MUST BE SIGNED BY THE LICENSED EMBALMER in his OWN HANDWRITING. (Failure to comply with the above constitutes grounds for revocation of license).

If embalmed by a STUDENT, he also shall sign in his OWN handwriting.

If this body is not embalmed, fact should be so stated above.